

## RISK QUESTIONNAIRE 6-9 YEARS OLD

NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ COMPLETED BY \_\_\_\_\_

### MENTAL HEALTH QUESTIONNAIRE

*Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.*

Does your child often seem:  
 Distrustful of others .....  Yes  No  
 Have trouble paying attention .....  Yes  No  
 Blame others .....  Yes  No

Do you have concerns about your child's:  
 Eating .....  Yes  No  
 Sleep .....  Yes  No  
 Weight .....  Yes  No  
 Does your child often complain of "not feeling well"? ...  Yes  No

Does your child have problems getting along with:  
 Parent(s) .....  Yes  No  
 Other family members.....  Yes  No  
 Friends .....  Yes  No  
 School mates .....  Yes  No

Does your child have problems at school with:  
 Behavior .....  Yes  No  
 Grades .....  Yes  No  
 Not wanting to go to school .....  Yes  No

Does your child often seem:  
 Sad .....  Yes  No  
 Angry .....  Yes  No  
 Nervous or afraid .....  Yes  No  
 Cranky .....  Yes  No  
 Not interested .....  Yes  No

Does your child often:  
 Destroy property .....  Yes  No  
 Lie .....  Yes  No  
 Steal .....  Yes  No  
 Hurt animals or smaller children .....  Yes  No  
 Is there a history of injuries, accidents? .....  Yes  No

If yes, please specify:  
 \_\_\_\_\_

Is there any history of maltreatment or abuse? .....  Yes  No  
 If yes, please specify:  
 \_\_\_\_\_

Is there a recent stress on the family or child such as:  
 Birth of a child .....  Yes  No  
 Moving .....  Yes  No  
 Divorce or separation .....  Yes  No  
 Death of a close relative .....  Yes  No  
 Fired or laid off .....  Yes  No  
 Legal problems .....  Yes  No  
 Others (Please specify): \_\_\_\_\_  Yes  No

Do you have other parenting concerns? .....  Yes  No  
 Please specify:  
 \_\_\_\_\_

Provider: Give details of **Positive** findings:  
 \_\_\_\_\_

### LEAD RISK ASSESSMENT (every well child visit from 6 months up to 6 years)

1. Has your child ever lived or stayed in a house or apartment that is more than built before 1978? (includes day care center, preschool home, home of babysitter or relative)  
 YES NO

2. Is anyone in the home being treated or followed for lead poisoning?  
 YES NO

3. Are there any current renovations or peeling paint in a home that your child Regularly visits?  
 YES NO

4. Does your child lick, eat or chew things that are not food? (paint chips, dirt, railings, poles, furniture, old toys, etc.)  
 YES NO

5. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur? (auto mechanic, ceramics, commercial painter, etc.)  
 YES NO

Your zip code \_\_\_\_\_ Risk area? ..... YES NO

(A "yes" or "don't know" response to any question indicates a positive risk)

**See page 2 for other zip codes**

### TUBERCULOSIS RISK ASSESSMENT

**Starting at 1 year of age and annually thereafter**

1. Has your child been exposed to anyone with a case of TB? YES NO

2. Was your child, or a household member, born in an area where TB is common (e.g., Africa, Asia, Latin America, and the Caribbean)?  
 YES NO

3. Has your child, or a household member, lived more than a year in an area where TB is common?  
 YES NO

4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)?  
 YES NO

5. Does your child have HIV infection? YES NO

(A "yes" response to any question indicates a positive risk)

### Heart Disease/Cholesterol Risk Assessment:

(2 years through 20 years)

1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death? YES NO

2. Has the child's mother or father been diagnosed with high cholesterol? (240 mg/dL or higher) YES NO  
 (A "yes" response to either question 1 or 2 indicates a positive risk.)

3. Is the child/adolescent overweight? YES NO

4. And is there also a personal history of:  
 Smoking? YES NO  
 Lack of physical activity? YES NO  
 High blood pressure? YES NO  
 High cholesterol? YES NO  
 Diabetes mellitus? YES NO

(A "yes" response to both questions 3 and 4 indicates a positive risk)

**RISK QUESTIONNAIRE 6-9 YEARS OLD**

NAME: \_\_\_\_\_ DATE OF BIRTH

COMPLETED BY